STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005003	A. BUILDING: _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE (	1501 HARTFORD ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was an investigation for a State hospital complaint. Complaint: #IN00143304 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005003 Survey Date: 09/12/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Franciscan St. Elizabeth Health- Lafayette Central is in compliance with 410 IAC 15-1.5-4, Medical Record Services and 410 IAC 15-1.6.2, Emergency Services, Hospital Licensure Rules. QA: claughlin 09/24/14	S 000		